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COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: DENTAL TAC MEETING

August 14, 2019
9:00 A.M.
Public Health Building
Conference Room C
275 East Main Street
Frankfort, Kentucky

APPEARANCES

Garth Bobrowski
CHAIR OF TAC

John Gray
Phillip Schuler
Heather Wise
TAC MEMBERS

Carol Steckel
Sharley Hughes
David Gray
MEDICAID SERVICES

CAPITAL CITY COURT REPORTING
TERRI H. PELOSI, COURT REPORTER
900 CHESTNUT DRIVE
FRANKFORT, KENTUCKY 40601
(502) 223-1118

APPEARANCES
(Continued)

Julie McKee
STATE DENTAL DIRECTOR

Jerry Caudill
Nicole Allen
Dale Miracle
Mel Fuller Taylor
Shelly Grainger
AVESIS

Ronnie Smith
Kwane Watson
Sabina Husic
DENTAQUEST

Jean O'Brien
ANTHEM KENTUCKY

Cathy Stephens
HUMANA-CARESOURCE

Mr. Stuart Owen
WELLCARE

Steve Hoagland
Melanie Claypool
PASSPORT

Rusty Cress
DINSMORE & SHOHL

Julia Smith
CFMC

Joseph Petrey
ORTHODONTIST

AGENDA

1. Call to order

2. Welcome and Introductions

3. Approval of Minutes for May 15, 2019

4. Reports and Updates
    1. Medicaid Fee-for-Service
    2. Anthem Dentaquest
    3. Avesis (Aetna, Humana, Passport, WellCare)
    4. Status of My Rewards Program/Sec. 1115 Waiver
    5. New Medicaid Program: KI-HIPP
    6. Public Health Director - Dr. Julie McKee

5. Old Business
    1. TAC Orthodontic Workgroup
    2. Recredentialing: Make this simpler?
    3. Eligibility: Patients upset - children were eligible two days ago at MD office but not now at dental office

6. New Business
    1. Passport/Evolent Health status and fee reduction
    2. Humana/Caresource partnership is terminated
    3. Aetna's new prior authorization requirement on narcotics for under 18 years old
    4. UK adult patients
    5. Dentists feel that it is unnecessary to continually repeat the time it takes to do attestations on fraud, waste and abuse and cultural competency
    6. How to handle "below cost reimbursement by the MCOs" and maintain a high standard of care as Humana has stated in their letter
    7. Possible patient abandonment (see State letter 7/12/19) Re: ortho but add endo or trauma cases?
    8. Other

7. Comments: Dental, hygiene, public

8. Motions to be sent to the MAC

9. Next Meeting - November 13, 2019

10. Adjournment

DR. BOBROWSKI: I want to welcome everybody to the Dental TAC meeting. I'm Dr. Garth Bobrowski and we've got all of our TAC members here. One could not be here today but we do have a quorum.

I would like to welcome everybody. We usually go around the table and just tell everybody who you are.

(INTRODUCTIONS)

DR. BOBROWSKI: Do we have anyone on the phone?

MS. HUGHES: Unfortunately, they removed the telephone from this room and I didn't know that.

DR. BOBROWSKI: So, we won't expect anybody calling in today, then.

We do want to give a special welcome to Commissioner Steckel and we want to welcome you for the first time to your meetings.

COMMISSIONER STECKEL: Actually, I think I've been here before. I am trying hard to attend all the TAC meeting but my calendar sometimes takes control over my life.

DR. BOBROWSKI: Thank you. We need a motion to approve the minutes from the last

meeting in May. There are a couple of typos. So, when we make the motion, we can say approved other than fixing some typos. So, I need a motion.

DR. GRAY: I move that we accept the minutes from the May 15th meeting.

DR. WISE: I'll second.

DR. BOBROWSKI: All in favor, say aye. Any opposed? Approved.

What I would like to do is just rearrange our agenda just a tad. We had formed an Orthodontic TAC Workgroup and I'd like to let them go ahead and give their report. It looks good.

DR. WISE: So, the workgroup consisted of myself, Dr. Caudill with Avesis and Dr. Watson with DentaQuest, Dr. Joe Petrey, orthodontist, a member of the workgroup, and two university representatives, Dr. Christina Perez from the University of Kentucky and Dr. Sudha Gudhimella from the University of Louisville. I hope I didn't butcher that.

So, we had two conference phone calls to discuss the task at hand and discuss an array of topics and basically came up with some recommendations we would like to present to the TAC for practitioners that are treating orthodontic

Medicaid patients.

And I can't say thank you enough to Joe and Dr. Caudill especially because they put in quite a bit of time after hours but these two gentlemen especially stepped up and I appreciate your help.

As we all know, this population is at higher risk, and actually, Dr. Caudill, I may have you share some of the information you found. You ran some data to show that the patients in ortho were at a higher risk and had numbers to prove that when they come in out of orthodontic, they had higher caries and restorative needs as far as billable procedures.

DR. CAUDILL: As requested by this group and the Orthodontic Workgroup, we ran internal numbers to see and compare this population of children that had had braces for roughly two years.

And, then, after they came out of the braces, how much actual restorative dentistry did they need compared to children that didn't wear braces during that same time period, and the kids in braces had substantially higher restorative needs.

I don't have the exact numbers

with me but it was a substantial number. It was like a third to a half more, a very substantial number.

And as we had talked about in our groups, I have had cases where I've been called by a general dentist or a pediatric dentist to look at an individual case because they felt the braces were being left on too long by the orthodontist and massive destruction had taken place.

So, therefore, we as a group were trying to come up with some guidelines for orthodontists who might feel hesitant to take them off for fear that they were taking something away from the patient; but I think the consensus is it's better to have crooked teeth than no teeth at all.

And we actually had cases where two years later, a child had to have all their teeth taken out and get dentures. So, cases like that are very, very, very few, but when they happen, it's very startling and stark. And, so, we're trying to come up with something to combat that.

DR. WISE: We want to be very careful not to just make the criteria specifically to orthodontists. We felt like all providers need to share because the every-six-month recalls, their dental home, they're going for their routine care

every six months. The general dentists, the pediatric dentists that are seeing those and have those relationships also have a reminder that we need to encourage the hygiene.

We know that patient accountability is not the best in this group, but the three main things we kind of came away with or the bullet points there were to remind all providers to encourage and enforce proper oral hygiene during their treatment.

These patients should be seeing dentists more regularly than those that are not in ortho treatment because they should be seeing their orthodontist every four to six weeks or so and, then, following up for restorative and routine care with their dental provider or dental home.

We also wanted to enforce and encourage regular visits by patients to their pediatric or general dentist for recalls. I do think a lot of patients feel like, well, I don't need to see you anymore because I'm seeing the orthodontist or they don't come back or they fail to show up for their every-six-month checkups, and that it is okay to de-bond the non-cooperative patients that consistently have oral hygiene.

Most of the orthodontists I deal with, they're scoring those patients at each visit. When they're seeing them, they're documenting, they're putting into the chart that their hygiene is not good, that they're not compliant with appointments, but before substantial destruction takes place.

And like Dr. Caudill said, when it does happen, it's not all the time but when it does, it's terrible. It's destructive and we don't want any patient or child to be without their teeth.

Avesis and DentaQuest did come together and said that they would approve every-three-month prophies or every-three-month fluoride treatments through the EPSDT Program which does require a prior authorization, and if there was a medical necessity for these patients that are at a higher risk with active ortho, orthodontic appliances on, not space maintainers and removable appliances but just fixed ortho.

Joe worked really hard on this, too, and was involved a lot. I want to certainly open the floor for you to say anything.

DR. PETREY: Sure. I think obviously it's a concern for all of us as dentists

but also as providers and orthodontists in the state for this population. We have to look, too, at the population itself. This is a population that we have a much more difficult time with.

The missed appointment issues in this population affect us from an orthodontic perspective where we'll have patients that will go months and months without making an appointment with us and, then, we see a significant caries or decalcification.

Decalcification occurs in 36 to 48 hours from plaque sitting on teeth. We're talking about patients that may go months without seeing us and that's difficult.

So, I think one of the biggest things from this are the three-month prophylaxis as well as the three-month fluoride because we're actually doing a preventive measure with these patients but making the appointments is so critical, both with us and with the pediatric and general dentists that are maintaining their care. I think that's the heart of this.

We also have issues that I think are easy to look over. In orthodontic care, we'll have patients that we have extracted teeth and

were bringing in impacted canines. It's very difficult to just say, you know what? We're going to stop here. It's very difficult to leave a patient with upper first pre-molars out with an occlusion that is going to cause significant dental trauma in the long term.

Certainly, we want to address the hygiene and such that we can continue them in treatment and get the outcome that we hope to achieve, and especially when we started down a path such as extractions or such as having Dr. Gray put a gold chain on a canine and try to pull it off of a lateral.

We want to save the adjacent teeth but we also want to save the teeth that are not part of the orthodontics that we're necessarily doing, and that to me is the preventive side of it.

For those of you who don't know, I also have a background in public health and prevention is the key in every aspect or what we do.

So, I think that, one, the three bullet points will empower the orthodontists and the general and pediatric dentists in the state to be able to look at something and see what we need to be able to provide, but also more importantly what

these two administrators have put forth as far as the prophylaxis as well as the fluoride on a three-month, I think we could see a significant benefit for the children in orthodontic care and I really appreciate you all making that effort.

And it is my understanding, everything is EPSDT, but in full-fledged orthodontic care, that will be considered medically necessary.

DR. CAUDILL: That's correct. I've run that through our Utilization Management Director also and he's a board-certified pediatric dentist and he agrees that that would be appropriate.

DR. PETREY: That's fantastic. Thank you.

DR. CAUDILL: That's what the EPSDT Program is. It covers additional codes but also increased frequency. In this cases, we're looking at frequency and we believe this is truly medically necessary when you've got a full mouth of braces and a child is not cleaning appropriately.

DR. PETREY: We had some providers that had some concerns that it would still require it to be medically necessary and how you define that as far as with hygiene and whatnot. So, I appreciate your all's efforts to say the problem is

the need and it's a preventative measure and not necessarily----

DR. CAUDILL: It's much more difficult to clean around braces. We all know that. I did braces for thirty years, as you know, and I went down this road myself and I had a three strikes and you're out policy. I would talk to the parents three times; and if three times didn't do it, it was better to have crooked teeth than no teeth at all. We took the braces off.

DR. HOAGLAND: Steve Hoagland. As the physical health provider here in the room, I feel fully uncovered in having this conversation, but I think the comment about EPSDT Special Services is really good and I think it's very helpful, but there's some pieces that we probably do need to think our way through a little bit and with the Department also.

Typically, those do require authorization, and I think the question about medical necessity determination is a really good one. And, so, are there opportunities for flexibility collectively that we can come together on because I think we would agree that this is really important in helping to prevent something worse down the line?

So, is there an ability to craft something thoughtfully that will allow more flexibility so that the authorization could be something you could say retro but a realtime encounter, when you have someone in the chair, trying to get somebody--breaking your work flow to get an authorization for something that is preventative in nature, how does that line up with other preventative services related to a different regulation?

Are there some counter forces there that we need to think about? I think me, it seems like value really outweighs some of the other processes that we would typically think about when using EPSDT Special Services. And that's me coming from a health plan hat.

Now, I can imagine that ultimately the grand arbitrator of all this may have some different ideas, CMS, and how EPSDT services are being used, etcetera.

DR. CAUDILL: Well, I can throw an example in how that has been handled in the past. When Avesis first came to Kentucky years ago, there was split billing and different things going on. And one of the things we did was to reach out to the pediatric community and find out, okay, about nitrous

oxide, laughing gas, what is an appropriate age to use that where it's pretty much always medically necessary?

And collectively they came up with the age of nine and under, and we went to our plan partners and we went to the State and said we would like to automatically adjudicate those and approve those without forcing the doctor to jump through all those hoops because we know it's necessary and we're going to approve it anyway, and that's what happened.

So, we do have a precedence for auto-adjudicating those kind of claims.

COMMISSIONER STECKEL: And certainly especially under EPSDT which basically the statute says any treatment, whether it's under the State Plan or not, that can ameliorate or treat or, and, then, there are a couple of words there bigger than that even, that they should be approved.

States - and not that I want you all to do this - but states have been very on the losing side of any challenges. I think states have won against hyperbolic chambers and some other kind of strange, very experimental treatments.

What I would recommend and what

would help us because under EPSDT, we're already paying the managed care companies to provide any service that helps a child, treats, ameliorates - and there's one other word I'm missing - diagnose.

So, the more you all can come together as a profession and say to us, this is the standard of practice. If a dentist, an orthodontist is doing this, they're acting within a routine, normal scope of business, knowing that if they're here, they're out of it and there should be a PA because there may be reasons why that should be approved and reasons why it's not.

I'd ask you to put on a Program Integrity hat. Not everyone is as honest as you all are, but understanding that where are the opportunities to take advantage of this.

But the more you can help us - and we're doing this in, of all things, drug testing, urine drug testing. We're bringing in the addictionology experts, we're bringing in the psychiatrists and where is that standard for ordering a test that's a 12-panel, 48-panel, a bigger panel.

So, yes, there is that opportunity, but I want the managed care companies to understand, it is already in your capitated rate.

So, if they come up with something, don't be coming to me asking for more money because it ain't going to happen.

DR. HOAGLAND: And the question wasn't around that. It was more around back in which program does it fit in, etcetera.

COMMISSIONER STECKEL: I understand. I understand, but I feel compelled that I have to say that; but in all seriousness, the more you all can help us define that middle lane so that we can get rid of the paperwork, get rid of the red tape reduction.

I had spent the day yesterday with the Governor. So, if I'm a little bit strident, you know why. But the more we can make it easier for you all to provide services, particularly for our children, we stand ready to do, and that is a function you all could provide.

Now, can I divert to my bureaucratic self? You have two options in doing this, and I would recommend that instead of calling this a workgroup of the TAC, that it's a workgroup of the KDA because if you call it a workgroup of the TAC, even if there's only one TAC member there, you have to comply with the Open records' rules, and I

don't believe you all did with this which is our fault because we didn't educate you.

So, if you all can be in a group as the TAC or an advisory group to the TAC and there's a TAC member there officially getting information for the TAC, then, it needs to follow the open records' rules.

Now, if the KDA is pulling together information or any other group, then, they submit that to the TAC, that's a different story. I don't want us to get into trouble because somebody then says, well, but this meeting was not legal.

DR. WISE: Can we call it a Dental Benefit Administrator Workgroup or the Avesis/DentaQuest Workgroup?

COMMISSIONER STECKEL: I would have it done--if you want to do it through the TAC, whatever you call it, if it's an official workgroup of the TAC, you have to comply with the open records' rules - I'm sorry - the open meeting rules.

DR. WISE: I would assume on the KDA, then, we would probably need to get permission and representation from the KDA as well.

DR. BOBROWSKI: We are from the KDA. We're the KDA's TAC. So, I don't think you

would have to. I'll take blame because we had talked about that before. And if you all have been around me long enough, you know that I forget sometimes, but we've talked about this and I let that slip my little gray head. We've talked about that.

COMMISSIONER STECKEL: And we should have been more proactive. It's not a blame game. I just want to make sure that the good work that has been done doesn't get challenged, not that I think there's anyone out there, but I've done this business long enough that if you all were to work on this PA process and somebody is left out, then, this gives them an out for challenging it.

So, there are two or three ways you could do it. If it is truly a subgroup of the TAC, then, it has to be in compliance with the Open Meetings' Act.

If the KDA convenes a group independent as a KDA participant and it happens to include TAC members but it's a KDA function, that's their business, even if they then say, Dr. Bobrowski, we would like to present to the TAC and make some recommendations.

Do you see the difference? I know I'm splitting hairs but I just want us to be

really careful.

DR. BOBROWSKI: Would it help like on our agenda today - I listed it down as TAC Orthodontic Workgroup. Do we need to maybe take a vote here or we can just do a Chair change and just put down KDA Orthodontic Workgroup.

COMMISSIONER STECKEL: I think what's done is done because this is sent out to everybody. Just going forward, we just need to be more careful about this because, one, I think the suggestion that you all had about helping us with the PA process and what should be a PA and what shouldn't, what's normal practice bands - I would love for you all to do that.

So, I don't want it to be risked by having someone who is unhappy with it coming out and saying, well, the low-hanging fruit is the Open Meetings Act.

DR. GRAY: If we as a TAC determine that a group would be helpful in this meeting about anything, can we suggest that we consult the KDA if there is a group and if they could get back with us? Is that a reasonable way to approach it?

MS. HUGHES: If you contact the

Dental Association and they say, yes, we've already got a workgroup on that or----

DR. GRAY: I'm saying today we identify another issue that we need a subcommittee for----

DR. CAUDILL: Can they ask for their input, I guess?

DR. GRAY: ----can we in this meeting suggest that we go to the KDA and ask for their input?

MS. HUGHES: Yes.

COMMISSIONER STECKEL: And, then, a report back to the TAC so that the meeting that the KDA has is not part of the TAC.

DR. GRAY: Okay. That clarifies it for me.

COMMISSIONER STECKEL: And I'm sorry to be such a stickler about this but I really am excited. Thank you for the suggestion because I really think this could help us all really streamline the type of work that we're doing.

DR. WISE: And I agree. I would like to see it as just kind of a standard we know. If providers are having to fight tooth and nail to get something paid for after the fact, then,

they're going to be less likely to utilize the preventive measures.

DR. CAUDILL: And this document is not a mandatory requirement thing. It's more of an informational thing anyway of what's already available. The EPSDT Program is already in place. They can already do this but they probably don't know they can do this, and we've kind of come up with general guidelines are appropriate because, in dentistry, we don't have a Milliman or InterQual or anything like that. We have to go out and create these from the literature, from research, meeting with the dental schools, committees like this with expert participation. That's how dentistry has to do it.

COMMISSIONER STECKEL: Sure.

DR. WISE: And communication is key and that's where we felt like we could just reach all providers that are treating this population, just remind our peers and our colleagues.

And communication is also key in working with our specialists. Dr. Petrey will pick up the phone and say I saw such and such today and there's a large lesion on nineteen. Can you get them in and see them. We work together and most

providers do.

DR. BOBROWSKI: A question on the prior authorization part of it, I know you all have got it already categorized which patients are in the orthodontic program approved in treatment.

Technically, we're supposed to have the prior authorization for the EPSDT part of those extra cleanings and fluoride.

Is there a way to say that, well, because we already know they're in the orthodontic program, could we waive that prior authorization part of it?

DR. CAUDILL: I think that's what we're talking about. We'll have to go to our plan partners. Can we do something like we did for nitrous?

DR. HOAGLAND: Right. I could see a couple of options. Not to get into the weeds too much, but I think from our perspective, one, you could create a bundle of services that would be inclusive of these additional preventative services that may historically have been provided through EPSDT Special Services.

Then, the second piece of that is what are the reimbursement models to support that?

One, do you increase the base fee as part of that bundle or do you allow them to go separate, and I think those are just kind of conversations, getting into the weeds of things that we would all need to sit down and figure out, but it seems like there's a path to being able to address that.

DR. CAUDILL: So, with our partners, we will certainly go back to them and strike up that conversation to find a way to make this happen.

DR. WISE: And we'll go back to the KDA and just change the wording.

DR. BOBROWSKI: Like most of us here, I'm leaving from today to go to the KDA annual meeting tomorrow and we've got a Medicaid meeting Saturday morning.

To be honest, I'm tickled to death that we've got the groups together and I think this is a positive move. As a matter of fact, I brought another picture just in case I needed it. These children are decalcified all across their teeth and cavities. I applaud everyone's efforts on working on this. It's great. I think it's a good step forward.

COMMISSIONER STECKEL: And we

are working with the University of Kentucky Dental School to bring on a part-time dentist so that we'll have a dentist fully back on staff. We had one and haven't been able to fill that position, but we're hoping in the next month or so, we'll be able to have a dentist on board that can work with this committee, whether it's KDA or whatever.

DR. BOBROWSKI: And I've got one other follow-up question. I know Ms. Guice sent out a letter July 12th concerning dental services and coverages and for the orthodontists getting paid.

It was mainly orthodontics but my question, too, was endodontics or sometimes thing that are multiple-step treatment, and I know the requirement under the KAR is that they have to be under twenty-one.

Well, if you're not finished with your orthodontic treatment but you're trying to get that finished or we've started a root canal, and just like Dr. Petrey says, sometimes they'll miss two appointments to make one, and with endodontic treatment, you've just got to finish that root canal or you're just leaving a wide-open swat for an extraction.

Could this be thought of as

abandonment of care or abandonment of a patient? I had this further down on the agenda today but I thought since we're talking about orthodontics, I might bring that up.

DR. McKEE: The patient and parent abandon the care before you get to that point.

DR. PETREY: That is accurate but I think you also have to look at the idea of the whole system and in the time in which we do our treatment, and I applaud Avesis.

And everyone with DentaQuest, I apologize for what I'm about to say, but my biggest issue as a provider with DentaQuest is they don't do this one specific thing, and that is when a patient gets treated and has been approved for a treatment prior to the age of twenty-one, as long as I have worked with them, has continued to cover their treatment because they understand that what we have done----

DR. McKEE: Until it's finished.

DR. PETREY: Until it's finished. That's correct.

DR. CAUDILL: Let me add that I was directed to do that by the Dental Director at

DMS. That was the standard that they expected us to adhere to, so, we did. But with that notice, that took that off the table unless something else changes.

DR. PETREY: With our other Benefit Administrator, that's not the case, and that's also not--at least in my practice, that's also not been the case. If I start a case with Avesis and that patient loses coverage throughout, I am still compensated for my work because I've already started that case.

MS. O'BRIEN: Even if they're ineligible.

DR. PETREY: Correct.

MS. ALLEN: Unfortunately, with the notice and with the direction that was provided, we can no longer do that. It' clear with Medicaid that Medicaid dollars cannot be used for a member that is not an active member or is not eligible for that benefit.

So, if a member starts their orthodontic care at nineteen or at eighteen and they're on a two-year plan or a two-year treatment plan, unfortunately, when they turn twenty-one and they're no longer eligible for that benefit, payments

cannot be released, or if they are terminated from the program or they're no longer eligible for their benefits, payment cannot be released.

So, because we did receive that direction in writing, and if I do remember correctly, the mailing was sent out to all of the providers also so that everybody is on the same page.

But initially as Dr. Caudill stated, and we've had that practice for years, we've been doing it for years and that was the direction that we received but recently it was clarified.

COMMISSIONER STECKEL: So, without leaving here and me not wanting to over-commit, one of the things that popped into my head, one, the PA work that you all are doing could help with this, too.

If we moved to a bundled service where on - and I'm trying to remember back when I had braces and all of that - do you give the parents a this is the two-year plan to what you said and this is what we're going to need to do, and at the end of two years, this is what we're hoping to achieve?

So, if that's the case, if we could go to a bundled service, almost a capitation

rate, and it would almost have to be a capitation rate because you'd have to be at risk for what if something within a certain margin occurs that you would have - I'm rambling, so, bear with me, guys, because I'm trying to think through how we could solve this - then, we've actually paid you. So, you're obligated to provide all those services until the package is complete.

The same with the root canal - my teeth are hurting. If we pay you for a root canal and anticipate kind of that risk, then, we've paid you for that root canal, whether it's one visit or three visits and that visit happens to go over a line.

Now, I say all of that without talking to my lawyers, one, and, because you're exactly right. If they're not a Medicaid eligible, we can't pay for it; but if what we paid----

DR. CAUDILL: But would there need to be a prorated recoupment is the problem because that happened once before with the oral surgeons is why I'm bringing that up with the RAC audit.

COMMISSIONER STECKEL: Or if-- let me explore this option. Write this down. Let's

talk to Lee about it because I'm not so sure in today's world, we might not be able to figure out a way to do a bundled payment. And understanding that if we do that, you all may have to take on some risk in that we do a bundled payment and we anticipate as much as we can of what is going to happen, but if they have an abscess that's not anticipated, that that's going to be a different scenario.

Let me explore with my folks and see if there's not a way to think through this issue.

DR. WISE: So, you're talking out loud thinking maybe you all would pay everything up front but, then, the provider would be----

COMMISSIONER STECKEL: Right, much like we pay the managed care companies. We pay them a capitated rate per member per month. And if that member--I mean, basically, we're saying at the beginning of that month, you're obligated to provide every Medicaid-covered service for that person.

There's a whole lot of other things that they're required to do, but if we were to come up with a way that we say either with orthodonture or let's use the root canal because it's clearly medically necessary.

So, we know that someone is on the cusp or everybody is always on the cusp - we hope they get a job and get off of Medicaid - so, instead of paying Payment 1, 2, 3 or 4, we pay a bundled payment that says for this bundled payment, you're going to do the root canal and any follow-up that has to occur around - and this is where we would need your help in defining it - around that root canal.

So, yeah, you'd have to be at risk. So, the point is, is it worth being at risk where it's a controlled risk or the risk you all have now is that they've dropped off of Medicaid.

DR. BOBROWSKI: The thing about the root canal part is it's billed a little differently than orthodontics because an orthodontist gets a good chunk of their treatment money a little earlier----

DR. WISE: But then they have to submit records to get----

DR. BOBROWSKI: The final payment, but with root canals----

DR. WISE: You submit the final x-ray----

DR. BOBROWSKI: ----you can't bill it until it is completed.

COMMISSIONER STECKEL: And that's what I'm saying. Let us explore moving that payment to the front but it would have to be a bundled payment.

DR. WISE: In this patient population, I don't think that's best. I mean, there's so many--if Joe treatment plans a patient and he says it's going to take me two years but they failed four appointments and don't show up and move and they come back, he's not going to get that treatment plan finished in two years.

DR. CAUDILL: Or the patient moves to Oklahoma or whatever and they've only got a third of the treatment done, do we recoup that other two-thirds because the doctor never did that treatment?

COMMISSIONER STECKEL: Okay. Okay. That makes sense.

DR. WISE: In my mind, bundling, I would like to see--I don't know what the fee is for an orthodontic standard case, whatever that is, "x" dollars plus, okay, it's going to take two years to complete it, let's offer four fluorides a year and build that payment into that bundled price is one thing, but I don't think that providers would

want to be paid up front and, then, have to fool with getting these patients to show up.

DR. CAUDILL: In the commercial world, it's usually an up-front payment and then quarterly payments?

DR. PETREY: It all depends. That does happen. There's also a lot of up-front, depending on who it is with, but they're moving more towards a quarterly.

DR. WISE: But your final payment is received after you submit final records.

DR. CAUDILL: Now, that being said, right now, Avesis pays like two-thirds of the fee right up front because that's a lot of chair time with the patient sitting there putting all the braces on. You've paid for all the expensive braces and bands and wires that go into that mouth that first day. So, we pay two-thirds of it right then.

And, then, six months later, we pay almost the other one-third. So, really, within six months, they've got almost all of their money. The last payment is just a minuscule amount to put the retainers in.

DR. PETREY: It is a capitation, in essence, though, because that fee is

set no matter how we treat and what we treat and what we do which is an aside because if we do good and competent care and treat with growth modification and appliances that cost us more money, our reimbursement is lessened.

And, so, I think good practitioners do the right thing and we try to, but there are practitioners that I know that extract teeth that don't need to be extracted just because that's the cheaper way to treat to not pay for another appliance and whatnot.

The capitation fee, though, there's a change in orthodontics with these programs. We used to be able to treat young children and have a Phase I orthodontics, an initial with baby teeth treatment.

Then, later, if they qualified - everything has to meet a medically necessary qualification before anything can be done - and I think ours is probably one of the, if not the most, stringent requirements as far as compensation.

Then, in adult dentition, if the patient had medically necessary needs, we could then apply for a Phase 2 fee and our Phase I fee was significantly less than our Phase 2. So, it's two

treatments.

That was re-interpreted when, Dr. Caudill?

DR. CAUDILL: Several years ago, they came out and said it was a lifetime maximum benefit for total braces and that's what we were directed to pay was a lifetime maximum benefit of comprehensive orthodontics - full treatment of the patient and that's what we did for years.

And, then, it was re-interpreted within six months, a year ago, somewhere in that range that, no, if the patient still met the qualifications in the KAR criteria, that, then, we can continue to cover that child under EPSDT.

DR. PETREY: What we had been doing in our practice, and I know a number of practices do, is we still treat by best evidence, best medicine, and we still treat a Phase I case, knowing that we're treating twice for a single fee.

That's very difficult and I would wager to you that we lose money on those cases but those are our most extreme cases.

We did get the ability for patients that are on the Children With Special Health Care Needs to have additional

compensation for cleft lip and palate and orthognathic surgery issues, but there are a number of children that have very significant, serious conditions that need to be treated twice, once in the mixed dentition and once in permanent teeth.

Then, if they're not with Children With Special Health Care Needs, we're capped at that single fee and that single fee is very challenging. It's challenging to treat with best medicine and best dentistry in the permanent dentition. To treat twice is extraordinarily difficult.

And I think it's caused a lot of our practitioners to stop many aspects of the program because of that and to stop treating these cases. I have orthodontists that send me cleft lip and palate patients that are two blocks down the street. My referral is from a practicing orthodontist that is a member of the program. He treats those cases but he knows he can't afford to. He sends them to us.

DR. McKEE: Because you can afford to?

DR. CAUDILL: You're saying a cleft palate case?

DR. PETREY: Yes.

DR. CAUDILL: At the fees they're getting for those cases?

MR. PETREY: Yes.

DR. CAUDILL: That's astounding.

DR. PETREY: Or the difficulty in treatment and the time in chair time is something more significant than him to treat that case, and I think there are orthodontists that won't see impacted canines which is ridiculous to me but there are risks with impacted canines to adjacent dentition that practitioners would rather just say no.

We already have a limited amount of orthodontists in the state that are accepting this. Of those that we have, if some of them aren't really accepting it, it makes those of us that are even more challenging.

DR. CAUDILL: If there's any doctors on the list because the Commission for Children has a specified list of practitioners who are allowed to treat the cleft palates, the cleft lip cases. It's not all orthodontists in the network because it takes extra skills to be able to treat those cases.

If we have practitioners on that list that aren't doing that or are referring them to you, I really need to know that and share that with the Commission.

DR. PETREY: True, but not all cleft lip and palate patients in this state are a member of the Commission with Special Health Care Needs and that's unfortunate. You and I have emailed back and forth about a case recently.

DR. CAUDILL: But the Commission is always open to bring those kids in and screen them and see if they are eligible. And if they are, it's an automatic.

DR. PETREY: That conversation for someone in Hindman, though, if they have to go to Lexington is not an easy one and it's not always able for them to do that. Some of these communities, there is no means of transportation for them and it's a difficult conversation to have.

And often by the time they make it to our clinic, that child is well past an age which surgery should have been done, an orthodontic should have been done well before the surgery to be able to make that happen.

DR. CAUDILL: I think that

would be a conversation that every orthodontist in the state should have with the patient saying your child probably would qualify for the Commission for Children for the coverage and can certainly receive this benefit.

DR. PETREY: We push for it but not everyone does.

DR. CAUDILL: I know they've got multiple locations. It's not just Lexington or Louisville where they go. It's scattered across the state.

DR. PETREY: The challenge, though, is that we do have essentially a fixed fee and that fixed fee has stayed where it is and that's where things are as far as the economics of the state, and cost to treat and difficulty of cases because of the way that we have to treat now has increased.

And as we are now treating two-phased orthodontics with a single case in many cases, we're doing essentially what you guys are talking about. We are taking these cases on and we are treating what the absolute need is, knowing that the patient will be back again for additional needs and additional finish and treatments.

And it goes back to the difficulty with some of the oral hygiene things when these patients come back as well and have poor oral hygiene and have active decay and whatnot, but it's a challenge from an orthodontic perspective.

It's also been a challenge from things looking at the letter that was sent out. Our practice has been part of the program since its inception and we have never had any issue accepting any of the plans.

One of the plans that left the state left us high and dry like many practitioners and that's the cost of doing business with less than honest people; but when we have patients that are in this population and for whatever reason they lose their coverage and they are told by the Benefit Administrator, which I was educated - I've always called you guys MCOs - by the Benefit Administrator that you now owe this orthodontist $1,000, that's difficult.

And that's difficult on our end, too, because now we have a collections' issue which I'm treating a child. I can't in good faith go to Mom and Dad and say, listen, you lost your coverage. Now you owe me money, money that they

didn't plan for or prepare for.

DR. CAUDILL: Can I ask a question? In your commercial patients with commercial insurance, if they lose their coverage or a cash patient then loses their job, what do you say to them, because that's the same thing as what you're saying here right now.

I mean, it's not just Medicaid patients. This is an ethical issue all orthodontists face, whether it's Medicaid or commercial.

DR. PETREY: I would argue it's not the same thing because that patient at the front end made a commitment and a decision to seek care and to have an economic requirement to meet.

A patient that is on these programs, they consider it a straight insurance that pays 100%. And when they then have a fee associated with the finish treatment, that's something that they either aren't able to do and many times parents are unwilling to do for these children. So, what do they do?

They still come to me and they still expect me to help their child and I'm not going to stop helping their child. I mean, it's not a house that you leave half painted.

DR. CAUDILL: And I've talked to other orthodontists about this recently because of the letter and they're all saying it's an ethical dilemma that we're in, that we started this treatment, they're halfway through and, then, they've lost eligibility. Even the AAO has numerous articles about this and debates about this internally and we discussed that also, and there's real no definite this is the way it should be done.

DR. PETREY: To me, the biggest risk is we have a program that already has a very limited amount of orthodontists that do do this type of work and do it more than just saying they do it but actually help a good number of kids.

DR. CAUDILL: Well, what precipitated this, we've been doing this for years. We've been covering this because we were told we should but, then, suddenly the encounters started not passing, I mean, just out of the blue, one day, boom.

So, we made an inquiry through our MCO partners and we were actually getting two different places inside of DMS both giving us different answers. Yes, we're aware of it and we're fixing it and, no, you can't do that.

So, that's why we pushed for an

answer in writing and that's what precipitated this because we were caught in the middle, to be quite honest with you. We're trying to do the right thing.

COMMISSIONER STECKEL: Well, and actually not to rationalize because you could get two different answers, but we're fixing it and you can't do it is actually the same answer. We're fixing it to the point we cannot pay a benefit for a beneficiary that's not eligible for Medicaid, period, across the program for any reason.

When we do that and CMS audits us, it drops to all state dollars which we have this hyper vigilance around making sure we're matching every single dollar we have in the Medicaid Program so that we can provide more services for more kids.

Now, one of the things I asked Sharley to help me remember to follow up on is for these kids particularly that lose their Medicaid eligibility, how are we trying to make the transition to the CHIP Program because it should be something that we automatically talk to the parent about, but it could be a situation where the parent just says no or I can't afford it or whatever.

So, let us look into that. Unfortunately, there's nothing we can do about--I

mean, I'm willing to explore any ideas or options that you all have. I hear your issue about the reimbursement rate, but there's nothing we can do about a beneficiary losing their eligibility. If they lose their eligibility, we cannot pay for anything.

DR. WISE: And I know we're not here to discuss policies, but it does seem that in communities where we live----

COMMISSIONER STECKEL: That is what a TAC should be is to discuss policy.

DR. WISE: It is disheartening to see families and I feel this way with the private insurance that loses their--maybe they lost their job, they lose their insurance, they're in treatment. Okay. They likely may have known that was coming or they choose to drop a private plan but this is the opposite.

It's like families have this coverage. They do expect that it covers 100%, but I see families losing coverage that are trying to do better. Mom gets a job. She makes $25 too much a week. They lose health insurance, dental, pharmacy, everything.

I wish the State would look to

hold the hand and let these families get on their feet and do right and move forward to kind of cushion. I know that KCHIP is there. They can pay a monthly fee to have their insurance, but when the rug is just pulled out from under them, then, what do they do?

COMMISSIONER STECKEL: Well, but we do have programs to try to ease someone off of Medicaid and, so, we do that. I just need to check into it and make sure Kentucky has it.

MR. OWEN: Could they transition to the Exchange?

COMMISSIONER STECKEL: They could. They could.

MR. OWEN: I mean, I know that would be a process and the parents would have to pay apremium.

COMMISSIONER STECKEL: And we spend a lot of time before we drop someone off of eligibility. We go through--believe it or not, even with the changes in the expansion population and all of those, I mean, there are like four hundred ways to become eligible for Medicaid, and before we drop someone off, we run through all of those.

So, it's not like you're off

the program. Now you're on your own. We really do try to work with them. Now we've got the KI-HIPP Program. If they get employer-sponsored insurance - I know we'll talk about that later - but we do try to work with folks so that it's not just an abrupt cliff, but Medicaid is a safety net program.

I'll tell you all a story and I don't mean to take up so much time, but I was a newlywed and married to a pastor who was working at the county hospital in Birmingham, and the headline in the newspaper that morning - I was sick as a dog, so, I was laying in bed with the covers over my head - and he went out to get the paper and the headline was Medicaid Commissioner won't approve a $1 difference for eligibility for this kid.

So, he comes slamming in to the bedroom, slams the paper down on me and said, how can you be so heartless?

So, the point is that that $1, if I were to do that $1, there's another person $1, there's another person $1. And, unfortunately, we have to have those limits because it's a safety net program.

Now, trying to be aware and sensitive to not dropping people and not leaving them

on their own is something we do try to do. And we're still married, by the way. It was close there for a minute.

DR. BOBROWSKI: Since you brought up the term eligibility, I do have that on the agenda today and there's continued problems with that. Like, last week, I put it down here, Mom is upset that the children were eligible two days ago at the M.D. office but now they weren't eligible at the dental office.

I put down there, how are these patients being notified of this status change because they're not being notified because Mom brought three kids in.

DR. WISE: We usually are the ones that find them because we look----

DR. BOBROWSKI: Yes. We check it every morning for eligibility status. So, how were they eligible like two days ago and then now they're not? The parent didn't know that.

DR. SCHULER: Is that in the same month because we were told the eligibility is a monthly eligibility, not day-to-day?

DR. McKEE: Not necessarily.

DR. CAUDILL: It used to be but I thought that changed.

COMMISSIONER STECKEL: Let me check into this. I don't know the answer to the question but let me check into it.

MS. ALLEN: Dr. Bobrowski, when you have those cases, if you could please give us the member details, let us follow up with the MCOs and see if there's something they can do to help us correct the eligibility and, then, in turn, they will follow up with DMS, but if you can please keep us in loop on those with your PR reps and we'll help to resolve them.

DR. BOBROWSKI: Speaking of PR reps, we don't have one. Nobody has let us know the name but we'll talk about that later.

MS. ALLEN: Okay.

DR. BOBROWSKI: But we've had families that come in, like, two of the children are eligible but the third one is not. It just doesn't make sense to us when we're trying to check these folks in. We have a staff member that comes in about an hour early every morning because we've been told that eligibility is a daily basis. So, I've got a staff member that comes in around 6:30 or 7:00 and

tries to get stuff done before 8:00 every day.

MS. HUGHES: I did ask when I got your agenda and we do send a letter out to the member. Of course, if two days ago they were at an M.D. and now we've been notified they're no longer eligible, two days hasn't been enough time for them to receive the letter.

DR. BOBROWSKI: I know, but they get upset with our front office staff. Some nice words are being said.

DR. CAUDILL: You get the brunt of it, yes.

DR. BOBROWSKI: We get the brunt of it.

COMMISSIONER STECKEL: Okay. Let us look into this.

DR. BOBROWSKI: Okay. I appreciate it.

DR. WISE: With technology, if I schedule a mammogram, I automatically get a reminder on my phone. With phone and emails anymore, is there a way to transition to an electronic notification when they enroll in the program? I know we're talking about a lot of numbers.

COMMISSIONER STECKEL: Great

idea. That would be great----

DR. WISE: I mean, our health insurance is that way.

COMMISSIONER STECKEL: Right, and you pay how much in your premiums and deductibles and copays and how much would you like your taxes to go up? And I say that somewhat facetiously. I mean, yes, that would be great and we're moving toward that.

I know the MCOs - sorry - the Benefit Administrators - I'm going to keep using MCOs because I'm old and I can do it - but they're using a lot of the text messaging component and, so, that may be the way we accomplish this.

So, yes, that would be great if we had the resources to do it. So, I'll add that to my list.

DR. BOBROWSKI: We're already doing that at our office, but the problem is a lot of them on their free phones change every six to eight weeks. That number is no longer good because if we didn't get a response off the automatic system, then, we try to call them - are you still coming - and we don't get any response or you'll get a response off the phone that says this phone is inactivated or

whatever.

So, some of them, they've got a two-month limit on their phones, so, that system is somewhat useful and somewhat not.

MS. O'BRIEN: If they use their minutes up to a certain point, then, when you call them, it will say that message. It will say that they're not available or it's inactive. They still have the phone a lot of times, but I think there would be more unlimited texting.

And the only reason I know this is because I just recently got somebody a phone and when I called that phone, I said it's showing as inactive and they were like, well, I called my brother and spent a lot of time talking to him. Well, you can't do that because it uses up all the minutes but most places have unlimited texting.

DR. HOAGLAND: We have the ability to, on the phones that we've helped people acquire through appropriate federal programs, there's ways of pointing for unlimited voice as well. You can point to particular numbers they can call - primarily they're internal - but there's been some flexibility there.

What we found is actually

available, most of our members, the phones that they have are actually not ones that we've helped them acquire through federal programs. It's a very small percentage actually even though you try to make that available. And as a result of that, there's very much a limit, although texting, I think, is still fairly free independent of the payor source.

DR. BOBROWSKI: The majority of my Medicaid patients come in with iPhones.

DR. HOAGLAND: Yeah, and we don't provide iPhones.

COMMISSIONER STECKEL: Sharley just texted - speaking of texting - just texted and eligibility is for a full month, so, from the first of the month to the end of the month, but let us follow up on the nuance of this. Why are you shaking your head?

DR. BOBROWSKI: See, that's what we discussed about at the last TAC meeting.

DR. McKEE: I hear from dentists all the time, they came in last week and they were covered. They came in this week in the same month, they're not covered. I also hear from health departments as well.

COMMISSIONER STECKEL: Okay.

Then, something is not working because it should be for the whole month.

DR. McKEE: Reputation has it that these are cases that the member has not done their due diligence in reporting of a change and they cut them off.

COMMISSIONER STECKEL: No. Even if we say they're no longer eligible, their eligibility is for that whole month. Let us check into this.

DR. WISE: And the communication between the State website eligibility and then the Dental Benefit Administrators.

COMMISSIONER STECKEL: Correct. Gotcha. Okay.

DR. HOAGLAND: I was going to say, not to throw us under the bus, those electronic file transmissions are not instantaneous, I don't believe. And, so, some of it could be a timing issue in one system or another. So, it seems like there's several places where that could happen. We just need to figure out what it appears to be. I'm not going to blame it all on an eligibility issue at the State level. This could be something electronic between all of us.

COMMISSIONER STECKEL: There's probably enough glitches to go around. So, we'll work down the pipelines.

DR. SCHULER: But the big issue, I mean, if the patients were eligible on a monthly basis, it would take a huge workload off the administrative folks at the office. When I talked to Lee Guice, she was pretty adamant about it's a monthly eligibility.

So, I don't know if it's at CHFS or at our partners or with you guys but we need to get it fixed.

MR. SMITH: To your point regarding the timing, so, one of the things that we've done, and I know we all say, too, is Kentucky HEALTH, it's the source of truth because that's going to be the fax updated because we do know the 834's have to travel from one place to another. So, that's the biggest thing.

We always continue to encourage if you see a difference between Kentucky HEALTH and, then, obviously our portal, then, we'll obviously adhere to what Kentucky HEALTH has. It could be simply again the 834's being processed as that member - it's being processed in our system as that member

is actually coming into the office.

And we've had that happen where, oh, where's that 834? We got it, we're processing it, and then they got eligible and they went straight to the doctor.

COMMISSIONER STECKEL: And are you all familiar with what we call the 834 Report?

MR. SMITH: Oh, I'm sorry.

MS. ALLEN: The eligibility file.

DR. CAUDILL: And you've all heard us say the same thing. The State site is the source of truth and we will honor whatever that says.

DR. BOBROWSKI: I want to keep us moving. Speaking of making things easier administratively for the doctors, I want to jump down here to, it's under Old Business of recredentialing. I put down there make this simpler, and I know other states are using this CAQH system.

COMMISSIONER STECKEL: Actually, we have the provider portals up and running. Are you all using it?

DR. BOBROWSKI: Well, yes, and I put down form number. I think it's the MAP-900 form.

MS. HUGHES: For revalidation.

MS. ALLEN: The Medicaid ID?

MR. CAUDILL: Is this the revalidation?

DR. BOBROWSKI: To revalidate with the State.

COMMISSIONER STECKEL: But you should be able to do it on the Partner Portal without having any paper at all.

DR. BOBROWSKI: We did something at our office a few months ago and, I mean, it wasn't one or two papers.

MS. HUGHES: Because the Partner Portal just went live for everybody and everything July 1st. So, if it was done before that, yes, you would have had to have completed that form but it's all now electronically that you can do it.

DR. GRAY: How long does it take?

COMMISSIONER STECKEL: It should just take I think I was told thirty minutes to do the application. So, the Partner Portal, when you go on, you fill out the enrollment application or the recredentialing application.

DR. GRAY: I'm just interested

in the time.

COMMISSIONER STECKEL: Yes. It should save a good bit of time. Now, I hesitate just as I was talking about the credentialing component. So, let me check into this.

DR. HOAGLAND: Sorry to jump in here, but for specificity, there are several components that we tend to think about, and I don't want to speak for our Benefit Administrators in the room, but the acquisition and maintenance of a Medicaid ID number is obviously a key part of things.

Then, there's the credentialing to be within the network which is related but technically separate from that. Without the ID number, ultimately you couldn't be within the network but that process is different. There's also moving towards a centralized credentialing process as well.

Then, I think - and this is my naivete - I apologize - but I think for dental providers in particular, as part of licensure and being able to participate within the network, there may be some additional things around chart audits or site visits, etcetera that I've heard and I seem to have heard in the past that have been a little bit cumbersome.

COMMISSIONER STECKEL: And that's why I hesitated when we----

DR. HOAGLAND: And I guess trying to understand exactly which piece it is helps try to find out what is the actual solution to this.

COMMISSIONER STECKEL: So, if you're talking about re-enrollment for Medicaid, that's the Partner Portal and that should speed up your process significantly if you use the Partner Portal, but that's enrollment for Medicaid.

Under current operations, you're credentialed with each individual MCO that you want to do business with and they have their own rules and processes that you have to follow.

We're hoping I say soon but I don't think that's realistic but we're hoping at some point in the near future to have a centralized credentialing component so that when you go on the Partner Portal, you can not only enroll or re-enroll but, then, you can pick a credentialing agent.

So, the Hospital Association by statute is already a credentialing agent, and, then, we're going out for RFP for another credentialing agent. So, you could pick one of the two of those and, then, they will do the credentialing

documentation for all of the MCOs that get the contracts for Medicaid.

So, it will be in one central place, one application and one process, but for right now, it's enrollment and re-enrollment for Medicaid under the Partner Portal and the credentialing, then, is with each individual MCO.

DR. BOBROWSKI: Of course, what I was talking about mostly was the recredentialing aspect of it.

COMMISSIONER STECKEL: And that would be with each individual MCO.

DR. BOBROWSKI: Right, but this one was with the State.

DR. CAUDILL: No. That's the revalidation.

COMMISSIONER STECKEL: Then, you're talking about re-enrollment and, then, you should be able to get your folks to--let me look it up, but you should get your folks to use the Partner Portal but let me see where you are in the system.

But in the future, if it's re-enrollment or enrollment into Medicaid to get your Medicaid number or to renew your Medicaid number, that should go through the Partner Portal.

DR. CAUDILL: And is that every five years?

COMMISSIONER STECKEL: Every five years, yes.

MR. GRAY: How often do you have to send a copy of your license in? How does your dental license get to Medicaid?

DR. BOBROWSKI: Every five years.

MR. GRAY: Do you send it in?

DR. BOBROWSKI: Well, we make a copy of everything and upload it.

MR. GRAY: The reason I ask is because one of the things we're working on already with the Kentucky Board of Nursing, we get a daily feed from them. So, if you're a CRNA or a nurse practitioner or a nurse midwife, you don't have to submit a license. We get that from the Kentucky Board of Nursing.

We are oh so close with the Kentucky Board of Pharmacy of doing that. In fact, I was talking to Rick Whitehouse yesterday about can we do something with the Kentucky Board of Dentistry to get a feed from them over to Medicaid. And, then, we're going to approach the Kentucky Board of Medical

Licensure.

So, that's just one more step that gets taken out of the equation. That way, we're always current with getting that feed. So, I'm assuming that's something that would be helpful.

DR. BOBROWSKI: It would be greatly helpful and my hair is grayer than yours because a lot of the folks that are here today weren't here a few years ago when we've had this discussion and we were told that one agent, one state agency can't talk with the other one to do that exact same thing.

MR. GRAY; Well, I will tell you it is happening today.

DR. CAUDILL: I'll jump in on this one. If you remember a few years ago, every dentist in Medicaid was getting ready to go invalid who hadn't sent anything in to DMS.

And I don't know if you remember. I jumped in, talked to the Board of Dentistry, was talking with DMS and got them talking to each other and the Board said, sure, it's another state agency. We can send it right on over and they sent a spreadsheet over within twenty-four hours and we kept like eight hundred doctors from going invalid

the next day. So, it can happen.

COMMISSIONER STECKEL: And, so, now what we're doing, yes, absolutely, and what we're doing is moving toward that electronic transfer so that it happens automatically. If there's a new dentist that gets licensed, it comes automatically over to Medicaid.

And for those of you that don't know David Gray, you should. David Gray is with the Secretary's Office. He is our Provider Liaison, guru, kind of helping us with a little bit of everything with provider relations.

But if it's enrollment, it's Medicaid and they should use the Partner Portal. Let me look into this and see where you are specifically. We shouldn't do this in the TAC but I will your specific issue; but if you all can encourage your members or your peers to use the provider portal, that will save them a lot of time, a lot of frustration and start the process. And, then, when we add the credentialing component, it will be like night and day.

DR. BOBROWSKI: We appreciate these comments and this discussion because, like I said earlier, we do have a Medicaid meeting Saturday

morning and I will tidy some of the words and terminology up and we'll start bringing that out.

MS. ALLEN: And I'll send you the notice. I'll send you the notice that DMS released regarding the portal.

COMMISSIONER STECKEL: Yes. And if you haven't gotten the message yet, and, I'm sorry, Dr. Gray, I'll defer to you, but if you all haven't gotten the message yet about communication among particularly the CHFS Departments but from the Governor with all Departments and Cabinets, it is a new day in this state.

Now, I'm new to the state, so, I haven't seen it as acutely but I've had people tell me that they've seen it, but trust me when I say that we are here to break down those barriers, not to let them continue.

Now, where there are legitimate reasons, we work through them, but nine times out of ten, when David has come up with something and we've needed to do, there's ways to make it work. And, so, that is this Administration's firm belief that we have to break down those barriers.

DR. GRAY: Once one is fully credentialed with everyone that they need to be

credentialed with, is there a good reason if we had the electronic data, if we have a license after that and it's active, is there a good reason that we should have to go through this reproduction and revalidation system? What purpose does that serve and is it a requirement if you have an active license?

COMMISSIONER STECKEL: The federal government requires us to re-enroll every provider, not just dentists, every provider every five years.

DR. HOAGLAND: And we have a requirement from NCQA to do that every three years. So, that's part of an external regulator accreditation.

COMMISSIONER STECKEL: And, then, we require them to be NCQA-accredited.

DR. CAUDILL: It's a requirement.

MS. ALLEN: Our recred period is every three years. We have to not only verify your license but also your malpractice insurance, all of that, your DEA, all of that information.

DR. GRAY: And we can't get that on if it's five years here, we can't--I mean,

the administrative burden of doing this in the office is incredible. I mean, it takes a tremendous amount of time and money to do it and they're not on the same schedules. It's just constantly. It's over $5,000 to recredential with a hospital, to get new credentialing through all the hoops you have to jump through and the hospitals don't talk to you all. They don't talk to you guys. I mean, it's constant and the cost is nearly prohibitive.

DR. HOAGLAND: I appreciate that. And from one organization, I can say it's hard to use absolutes in what we do. And, so, is there a path to something different?

I would say there is. There would be a process, but if our client says you absolutely have to do it this way, then, there generally is a process for an exception from our external accrediting body where we go through and say, look, there's a law, there's a regulation where we operate that says it has to be done this way and we can get special dispensation generally in doing that, but there is a process that we have to go through to make that happen.

COMMISSIONER STECKEL: Now, the problem is with the hospitals, and I'll raise this

with Nancy Galvagni, but with the credentialing and recredentialing component of our provider portal, that should help because someone would be able to see--it may be that we require every three years but you'll be able to do it electronically----

DR. GRAY: The only real answer is a national database. St. Joe, Baptist, whatever you want to look, UK all have their own credentialing. They are going toward a national database but we need to be going as a state and as MCOs, the providers, we need a national database where you fill out all this stuff one time and, then, whoever you want as a provider, authorize them to have access to it and it's done, but it's incredibly spread out.

DR. CAUDILL: Once we have the centralized credentialing of one agency, that will cover dentists, physicians, everything, right?

COMMISSIONER STECKEL: Right, all providers but it won't cover their need to credential with the hospital unless we can work something out with the--well, the Hospital----

MR. GRAY: Hospitals recredential all providers every two years.

COMMISSIONER STECKEL: So,

you've got a two-year, three-year and a five-year process.

DR. GRAY: Plus Humana, Avesis, Passport, Delta Dental. I mean, it's a one-person job. It's a one-person job and they quit because they're so sick of it.

COMMISSIONER STECKEL: Well, when we get our credentialing component up on the provider portal, that will take it from five to one. So, at least that part will be condensed.

MS ALLEN: And with the Avesis recred, we do do that at one time for all of the MCOs that we do administer. So, for us, it's one for four.

DR. CAUDILL: As it stands right now anyway.

DR. BOBROWSKI: All right. Thank you all for that. I've got two more things under Old Business from our last meeting. Ms. Bennett was----

MS. ALLEN: She's not here today.

DR. BOBROWSKI: Okay. She was going to give us a report on some CPT codes.

MS. ALLEN: If you could share

it with me, I'll get it back to you. I apologize that we don't have that today. Do you have the CPT codes? Do you want to email them to me?

DR. BOBROWSKI: I'll just get with you. Let me make a note here.

MS. ALLEN: Okay.

DR. BOBROWSKI: And, then, Stephanie Bates is not here also today. She was going to give us an update on some data requests that were tabled from the last meeting. So, she is not here today, so, we'll get back with her.

Now, I'm going to go back up to reports and updates under the Medicaid fee-for-service. We'll just go down through there. Does anybody has reports from the Medicaid fee-for-service?

Anthem? DentaQuest?

COMMISSIONER STECKEL: Can I stop here? As you all, many of you more acutely than others, know, we're in the midst of an RFP for our MCOs. I would ask that any specific discussion about a specific MCO, you all put that at the end of the meeting and DMS and David are going to have to leave the room because we can't be part of that discussion.

So, if it's about dental

services with all five MCOs and it's a current operation, we can talk about that; but if you're going to hone it down, which is entirely appropriate, to a specific MCO, we can't be part of that discussion.

DR. BOBROWSKI: It's open meetings.

COMMISSIONER STECKEL: It is, but we can't be part of that discussion because it then calls into question our objectivity. Even though I'm not part of and Sharley and David are not part of the actual committee making this choice, it's just a decision. We'd rather be careful than not.

DR. BOBROWSKI: That's fine. Let me move that part to the end of our meeting for day.

From what I understand, the status of the My Rewards Program and the 1115 Waiver is just everything is on hold?

COMMISSIONER STECKEL: Yes, sir. We have a hearing on October 11th before the D.C. Circuit Court, I believe the D.C. Judge. And, then, we expect a ruling two to three weeks after that. We fully expect that whoever does not prevail in that ruling will appeal it to the Supreme Court.

We are not anticipating any action on the 1115 Waiver except for the SUD component which we have implemented effective July 1st but nothing else until July 1st of 2020.

DR. BOBROWSKI: And we do have a report on the KI-HIPP Program and there was a paper that went around.

COMMISSIONER STECKEL: This is a very exciting program that we're pleased to announce that we are expanding and we're doing a significant amount of outreach on.

The KI-HIPP Program is a program we've had in place but we haven't opened it up to every Medicaid beneficiary being able to apply and now we have.

Basically, for Medicaid beneficiaries that have access to employer-sponsored insurance, they can ask us if they're eligible or they can come in and ask to apply for KI-HIPP.

We do a cost benefit analysis. Would it be cheaper for Medicaid to pay for their premiums and their deductibles, in essence, buy them into that employer-sponsored insurance than to pay the Medicaid cost for that person.

Then if it is, they apply for

their employer-sponsored insurance. It is a, not a life-changing event, but it's that rule for private insurance where you can apply even if it's mid-year or not open enrollment.

So, they will apply for their employer-sponsored insurance. They have to pay their first premium. We reimburse them and then we wrap around that employer-sponsored insurance and pay all of the Medicaid covered services' premiums and deductibles.

Now, it helps not only for that employer, but as many of you know, the employer-sponsored insurance, the family benefit oftentimes is more expensive than the single. If we can show that it's cost effective, let's say there's a child in a family and the parents come in and ask us to run the cost-effectiveness tool and it's effective for us to cover that child with a family premium benefit, we can do that.

And, so, what that does is allow the family to be covered with us paying the premium. Now, they would have to pay the deductibles, the copays for the non-Medicaid eligibles but at least it opens up that insurance plan for those beneficiaries that have that one

person or two people, kids that are in the family.

So, it's a very exciting program. We've given you this flyer because it shows you how to get in touch with folks to ask about it, to see which insurance plan might work and might not. And in many cases, we'll run two or three plans that the employer has. I mean, it's not just one and done. We'll help that beneficiary look through everything.

The last time I checked was last week and we have 107 members that have enrolled recently and it's saving us $40,000. So, it is one of those win/win situations. It helps our beneficiaries to get into their employer-sponsored insurance and it helps us with the budget.

Now, the one thing I will caution everybody about is it does expand the network in that they can go to anyone that's on that employer-sponsored network even if they're not a Medicaid enrolled provider; but if they go to a provider that's not a Medicaid enrolled provider, they're liable for those expenses, so, the copays, the deductibles.

Now, I think less than 9% of the providers in this Commonwealth are not Medicaid

providers. So, that's the good news. And, then, we'll work with that member to try to get that provider onto the Medicaid Program, but that's the one caveat I just want to make everyone realizes. Just like we have to look at our insurance plan to make sure our doctors and referrals are all in the coverage policy, so do the Medicaid beneficiaries, but if they're Medicaid eligible, Medicaid wraps around all of those services.

DR. McKEE: Is this time limited like for a year, two years?

COMMISSIONER STECKEL: No. As long as your insurance policy is cost effective to the Medicaid agency, we'll continue to pay for it and as long as you're Medicaid eligible.

DR. McKEE: Right. You have to remain Medicaid eligible to even be considered.

COMMISSIONER STECKEL: Correct.

DR. McKEE: So, if you get a promotion, you may not----

COMMISSIONER STECKEL: Correct, but now you're in your ESI program and hopefully that helps you. And if not, it helps you with the Exchange. Someone mentioned the Exchange. So, there are transitions there even, but now you know how the

ESI system works. You're familiar with it and making that transition hopefully will be easier.

DR. GRAY: If you're out of state, if you have a Medicaid child that's in an accident, for instance, in Florida, out of state, how does that work and they require medical care?

COMMISSIONER STECKEL: If they're Medicaid eligible, it's----

DR. GRAY: No. They have the Medicaid services and they are eligible but they're in an accident in Florida. There's no providers there to take Kentucky Medicaid.

COMMISSIONER STECKEL: I's an emergency.

DR. GRAY: So, that takes care of it?

COMMISSIONER STECKEL: Yes, sir.

DR. GRAY: And this other program would be the same way?

COMMISSIONER STECKEL: Yes, sir.

DR. GRAY: And there would be, although the parents would have their deductibles on the child that is covered, Medicaid Services would

cover all those just like they do for Medicaid?

COMMISSIONER STECKEL: Yes, sir, just like the traditional Medicaid Program, we're going to wrap around.

Now, where that $40,000 comes in is that the employer-sponsored insurance now is paying for the doctor visits, the hospital visits. They'll actually pay for that emergency room visit. We just wrap around what's Medicaid covered but not covered in the employer-sponsored insurance including deductibles and copays.

DR. GRAY: It sounds like it would be a win/win.

COMMISSIONER STECKEL: It really is a phenomenal program. It's a learning curve - I don't deny that - but it is a phenomenal program to help our beneficiaries get into the private insurance market and start learning about that, taking control of their health care decisions, and, by the way, it saves us a lot of money.

DR. WISE: How is this information being presented to the public? Is it out there on social media?

COMMISSIONER STECKEL: Yes, yes, yes and yes. Any way we can. We're mailing

letters to all the beneficiaries that we've identified that have access to employer-sponsored insurance. We're talking to all the advocates, the press, social media. Actually, we will be at the State Fair. If anyone is going to the Kentucky State Fair, come to our booth, please, but we'll be there talking to folks about it. Where two or more are gathered, we'll be glad to talk about it.

MS. HUGHES: I think I've sent you all the link to the website and it not only has beneficiary information out there but it has employer information.

So, if you know somebody that employs folks that are maybe lower income, that they would still qualify for Medicaid, there's information for the employer to use that they can talk to their employees and say this is a benefit we can offer you. You can still keep your Medicaid and have the employer insurance. So, there's a lot of good information out there.

COMMISSIONER STECKEL: And we're working with employers. We've identified the top employers in Kentucky and we're reaching out to them, too, so that they know about it; but the more you can help us with this, the better it will be for

everybody.

MS. ALLEN: When we get back, we will share this with Provider Relations Representatives. As they go out and do their visits with the dental offices, they can share this information. We'll go ahead and make the copies and everything but we'll get these out to the dental providers. It is a great program.

COMMISSIONER STECKEL: That would be perfect.

MR. SMITH: I was just kind of thinking, processing it in my head. I know you have Medicare could be a primary payor. We do that now, and I know we send that. Thinking about encounters, of course, but I was just trying to note something.

We'll send that COB information, and within the encounter, I was trying to foresee anything there regarding the----

COMMISSIONER STECKEL: Right. So, for the provider, they hopefully will bring both cards, but if they don't, the system will pick it up. So, you would do like any third-party payment. You would bill the employer-sponsored first and, then, the system will pick up the rest of it and send you the Medicaid component. Now, that's a good question.

I should have started with that.

MS. HUGHES: Are you with an MCO?

MR. SMITH: I'm with DentaQuest, Anthem.

MS. HUGHES: Okay, because what happens is when they get on KI-HIPP, they actually come out of the MCO.

COMMISSIONER STECKEL: Thank you. I'm sorry. Yes. Sorry about that. They will be moved into fee-for-service out of the MCOs. I'm sorry. But, then, for providers, you will bill just like any other third party, the employer-sponsored insurance first and, then, the system will pick up the Medicaid component of it.

DR. BOBROWSKI: We will be reimbursed at the fee-for-service rate is what I understand.

COMMISSIONER STECKEL: You'll be reimbursed at whatever that employer-sponsored insurance rate is first.

DR. WISE: What if they don't have dental benefits?

COMMISSIONER STECKEL: Pardon me?

DR. WISE: Many employer-sponsored insurances don't have dental benefits.

COMMISSIONER STECKEL: Well, if that's the case and they don't have children, then, Medicaid will pick--I don't know specifically but it could either be that that won't be cost effective or Medicaid will pick it up. So, it just depends on where it falls on the cost-effective tool.

DR. McKEE: It's also a great opportunity to educate the beneficiary that when they move to full ESI, they need to budget for their personal dental.

DR. WISE: Didn't the commercial plans and private plans just move to--the medical plans had to have dental and vision coverage just for kids?

DR. McKEE: Yes.

COMMISSIONER STECKEL: So, all of it starts with that cost-effective tool, looking at all the ESI plans and, then, the Medicaid cost and which one is below the Medicaid cost. And, then, after that, it's a matter of Medicaid wrapping around.

So, if it's cost effective and the ESI doesn't have a dental plan, then, Medicaid

would pay and that would be under the Medicaid fee-for-service, but if it's covered under the ESI, and most providers are making this connection, then, you will get reimbursed under the ESI reimbursement rate, not the Medicaid reimbursement rate.

DR. WISE: And, then, those companies will stop dropping their fees to below Medicaid.

DR. BOBROWSKI: See, that's the other side of this.

COMMISSIONER STECKEL: Yeah, but I doubt--I mean----

DR. BOBROWSKI: No. It's happening. Delta Dental is already paying less for a child's cleaning than what Medicaid does.

DR. WISE: That's my threshold. If I'm going to become a provider, I will look at the reimbursements, and a lot of the private plans now pay less than Medicaid.

MS. HUGHES: Well, that's good to know, isn't it?

MS. CLAYPOOL: I was just curious. Do you have a number of about how many were identified that could be potentially eligible?

COMMISSIONER STECKEL: There

are over 80,000 people on Medicaid that have jobs and that's a myth about Medicaid is that people don't work. They do, in many cases, two or three jobs. So, it's just a matter of how do we empower them? How do we give them tools to take control?

I often think, and I've been extremely blessed in my life, but there for the grace of God, go I. So, I could have made a few decisions and still could probably make a few decisions that get me into a situation where I need help and I need that step up. So, how do we provide that?

And this is a tool that allows us to do that. It allows the mom to take control for her kids and get into the workforce, get into the ESI. I just think it's an exciting program.

MS. HUGHES: And we are in the process of notifying members if it isn't in our system. We sent 10,000 letters out like in May. We send around 35,000 on August 5th. I think we're sending another 35,000 out around September, something like that.

If they're ever indicated in our system that they work, the first one, 10,000 was if you work and you indicated you have other insurance, we sent those letters out.

Now we're sending them out to the two 35,000 people, groups that just say I do work. So, we're sending them a letter that says since you have indicated you work, if you have employer-sponsored insurance available to you, we will help you pay the premium if it's cost effective. So, we're letting them know so they can contact us and send that information.

COMMISSIONER STECKEL: And do encourage people to call and ask questions because this is all about trying to find the right fit and making sure that we're exploring all the options that that beneficiary has available to them.

AUDIENCE: My question was, is there going to be a directory that matches up the commercial insurance and Medicaid because in order for this to work, it seems that the provider would have to accept that commercial insurance as well as Medicaid in order for it to work because if the provider doesn't accept Medicaid, then, it only covers the commercial insurance part and, then, whatever Medicaid would cover wouldn't be covered or vice versa.

COMMISSIONER STECKEL: That's part of what we're trying to teach the Medicaid

beneficiaries. Just like you and I for our insurance, we have to look and see which providers are in our network. We're having to educate our beneficiaries that they've got to look in this case twice almost. You already have to have a Medicaid provider network. We provide that and, then, your insurance company provides a provider network listing. The Medicaid beneficiary is going to have to look to see, you know, hopefully it's a Medicaid provider. If not, then, they will know that if it's an ESI provider, that they're going to have to pay those costs.

AUDIENCE: Because I didn't know if it was going to be like a separate thing just for this where they could check and in one look-up, they could see both.

COMMISSIONER STECKEL: No, because there are hundreds and hundreds of ESI combinations out there. It would just be so prohibitive, and the potential for making a mistake would be so high that we wouldn't want to misinform someone.

So, it's better to teach folks how to, just like when you went through orientation, like, I assume, we went through orientation for our

insurance plan, that that's what it would be like for the Medicaid beneficiary.

AUDIENCE: Right. And I assume that's going to go out in a communication, like, they will receive a communication as this goes along that tells them like where to look and what to do. I saw the letter that was sent out. I've actually seen one of those but I didn't see on there where it specifies like you need to check both places or to make sure the coverage matches up.

COMMISSIONER STECKEL: There's a member handbook that will go out that will explain that.

AUDIENCE: Okay.

COMMISSIONER STECKEL: And we've actually sent it out to a group of advocates that live and breathe with our beneficiaries and asked their opinion on the member handbook to make sure we're communicating it accurately.

AUDIENCE: Okay. That's good to know because that's the kind of questions we would want to know is how can I be sure.

COMMISSIONER STECKEL: Sure, exactly. Good questions.

DR. BOBROWSKI: I'm going to

move us along. Ms. Steckel brought up a point of the State has to look at cost effectiveness. The Benefit Administrators have to do it. It's just like Dr. Petrey said. Even the orthodontists, the general dentists, we all have to look at cost effectiveness.

You've gotten a lot of letters. David Gray has gotten a lot of letters. I'm getting a lot of phone calls and I've got about a four- or five-page letter I brought with me. We're not going over it but the reduction in reimbursement from the Benefit Administrators on certain procedures is about to reach critical mass.

With those reductions - I'm not going to spend a lot of time on it unless we've got time - but providing services that we do a lot of on a daily basis is below cost.

And a lot of the dentists, they're showing up as providers but they're limiting their scope of practice or limiting it only to children and these are some of these adult rates.

And I just want to bring that up that I think it's going to have to be addressed or more and more adults are going to not be treated.

COMMISSIONER STECKEL: Well, and I apologize for being on my phone while you're

talking but I was looking up, on the 21st, my staff and I are getting together. David is part of that conversation.

We pulled some data that has us motivated to I'd say take action, but anytime I say that, it costs money. So, we recognize this is a critical mass and it's not just trying to tell you what you want to hear.

We've got data now that shows us it's a critical mass. It stunned--I think all of us that saw it were stunned.

And, so, on the 21st, we're getting together to meet to discuss what we do, how we deal with it, what the costs will be and, then, we'll be coming back out to you all to talk about it in more detail. And this is a systemic thing. It's not one MCO versus another. It is a systemic issue.

So, you've got my word that this is a top priority with us. We recognize how serious it is and the data, not just the volumes of letters, although that's important, the data that we've seen has shocked us and we know we've got an issue that we have to deal with.

DR. BOBROWSKI: Even last week, I was up until 1:15 one night, 1:30 the other night

getting data. It's like you said, you were getting some data. And the letters and the phone calls and the texts that I've gotten, I mean, dentists are really concerned about being able to provide this service.

If the State is not going to pay an adequate fee for this service, well, then, don't even offer it is what they're saying.

COMMISSIONER STECKEL: And rightfully so. And I promise you all that we are just as anxious about this as you all are. I know you feel more acutely because it's your business and you're paying staff and all of that, but I can't tell you strongly enough that we know we have to do something. We just have to get together to figure out what can we do, how can we do it, how can we afford it.

The good news, the silver lining in this discussion at this point in time is we're putting together the budgets. So, that's the good news, but I promise, on the 21st, we're meeting about this. We know we have to do something about it.

Now, what comes out of it, I don't know the answer to that but we have the data.

We see the issue and we know we've got to do something.

DR. BOBROWSKI: Because I know, for instance, Passport has got a deadline of September 1st - sorry - cover your ears.

DR. CAUDILL: I was going to say, we're getting into individual----

DR. BOBROWSKI: Well, let's just move on.

COMMISSIONER STECKEL: Thank you. Thank you.

DR. BOBROWSKI: But it's getting critical mass out there to provide services.

COMMISSIONER STECKEL: And I will remind all the dentists that - and I'd say this to every provider - signing that contract is your decision.

And one of the things that we will look at both with existing MCOs and the new ones before they sign on the bottom line for the final contract is network adequacy.

So, I will just leave that with you all, but know that we are focused on this and we know we've got to do something.

DR. GRAY: For that meeting,

would you like to have any dental input since you don't have a Dental Director?

COMMISSIONER STECKEL: Not for that meeting because the data is so crystal clear. A lot of it is just working out numbers.

DR. GRAY: When one talks about things like adequate networks, that's a good topic to have, but the reality of it is that that may not be possible or is not possible in this state with this reimbursement. We are losing people, as I'm sure your data will show you. East of I-75, there are no practitioners going there. There are none going to be going there.

So, you can tell the MCOs that you have to have an adequate network but, yet, they can't get it. It's not going to be possible.

COMMISSIONER STECKEL: I understand, but the meeting on the 21st is to talk about reimbursement.

DR. GRAY: That would go some at addressing that.

COMMISSIONER STECKEL: And, again, I can't promise anything but we clearly see a crises issue in reimbursement.

And there are two - and I can

say this because I'm going to say it about the systemic issues - there are two issues. One is Medicaid fee-for-service paying appropriately, and that's one of the issues we're going to talk about on the 21st.

The second is are the MCOs paying appropriately under our capitation fee or is the capitation fee too low.

So, those are the types of issues on the 21st. It's not even about network adequacy. It is about the reimbursement because you're exactly right. If that's not right, it doesn't matter what we enforce. Does that help?

DR. GRAY: Yes.

DR. BOBROWSKI: Thank you very much. It's enlightening, informative, beneficial.

DR. SCHULER: The meeting is on the 21st of this month?

COMMISSIONER STECKEL: Correct. And I'll tell you that very few times in the thirty years of me doing this have I been shown a set of data that dropped my jaw but this did. So, now you've got our attention and we are hoping to be able to deal with it.

DR. SCHULER: Well, if you just

look at how long it has been since there's been an increase. Our cost of doing business has not gone down ever.

MS. ALLEN: And it's an overall increase. The increase that was provided was only for preventative but the overall fee schedule has not been reviewed I think since 2013 or 2015.

DR. BOBROWSKI: Two thousand and two.

DR. CAUDILL; And that was only for the children it went up. It didn't go up for the adults.

DR. SCHULER: So, I'm sure your data is showing some issues.

COMMISSIONER STECKEL: That would be an understatement but let us work on this and know that we've heard you, heard your peers and recognize there's a problem, a serious problem.

DR. BOBROWSKI: Now, one other thing I want to bring up under New Business, too, while you're here and, then, I think the rest of it is going to be individual Benefit Administrators, so, we want everybody to have an opportunity to talk to you if you're willing.

COMMISSIONER STECKEL: I'm

here.

DR. BOBROWSKI: And, then, we can let you go and we'll go down to the other things if we've got time to stay here.

DR. McKEE: Julie has stuff to talk about with Medicaid, too.

DR. BOBROWSKI: I was going to get to that.

DR. McKEE: I wanted her to hear what I have to say, too.

DR. BOBROWSKI: Go ahead.

COMMISSIONER STECKEL: Are you a member of the TAC? I'm sorry.

MS. HUGHES: She's with Public Health.

COMMISSIONER STECKEL: This really should be the TAC members. If you and I need to talk, we can do that, but this really should be the TAC members.

DR. BOBROWSKI: What I have historically done is kind of set the agenda up, and if I'm wrong, I apologize, and we may have to do a different route, but I've tried to have it kind of as an open meeting with the TAC members obviously asking the questions but sometimes I've opened the floor up

to our State Dental Director, Dr. McKee, for things that's going on in the public health arena that we need to look at. So, that's why I've got her name on the agenda.

COMMISSIONER STECKEL: I understand but Dr. McKee should be working with Medicaid, not through the TAC.

DR. McKEE: It wasn't a request for Medicaid. It was information about Medicaid.

COMMISSIONER STECKEL: Well, you should be calling us directly. That's part of that lowering barriers. The Health Department and Medicaid should be working together. We shouldn't need the TAC to make that interaction.

DR. GRAY: I have a question about that because to adequately be a Technical Advisory Committee, we need input from Dr. McKee, too. So, how do we get that?

COMMISSIONER STECKEL: Well, but you're an advisory committee to the MAC which is an advisory committee to Medicaid.

DR. GRAY: Correct, but to be an advisory committee, we also have to know what's going on in the state which is why we're here.

COMMISSIONER STECKEL: But Dr.

McKee is with the Health Department, not with Medicaid. You're a very valuable part of the community and work we're doing but I don't understand. I'm missing something.

DR. GRAY: I think so. I think so. I think that what the Health Department is, how that affects the care of our children in this state. The advisory committee needs to know what they're doing because there are a lot of programs that intersect and we as an advisory----

COMMISSIONER STECKEL: But they're Medicaid Programs and you're advisory----

DR. GRAY: Some are, some aren't.

COMMISSIONER STECKEL: Well, but that's not the purpose of the TAC. If you want to meet with the Health Department about their programs, please feel free to do that. That's not the purpose of the TAC. The TACs are policy advisors to the MAC which is a policy advisor to the Medicaid agency, not the Health Department, not Behavioral Health and not DAIL.

DR. BOBROWSKI: I gotcha. Okay. I put down here UK adult patients. We called UK and apparently they have changed policies or the

person we talked to says they only will take adult Medicaid on a referral basis. Now, that's what we were told.

In a way, that's a shock to me but I didn't know if anybody else had any other information about that or was this person telling me incorrect information but that's why I put it on the agenda to talk about it because that's sad in a way that a state university can't see our Medicaid patients.

MR. SMITH: We've always sent Medicaid adults to Kentucky. So, I don't know if it was a one-off maybe.

DR. CAUDILL: I do know their Oral Surgery Department has been decimated and Dr. Gray knows that, too. They've lost some people. One is on maternity leave.

DR. GRAY: They're down 33 to 50%.

DR. CAUDILL: One passed away. It's just been----

DR. GRAY: They're not covering clinics. They're not seeing patients. They don't have the staff to do it.

DR. CAUDILL: They've been

decimated as far as manpower for oral surgery. I do know that.

DR. BOBROWSKI: And, then, I got a phone call from another dentist that another oral surgeon in Eastern Kentucky, he was doing a limited area but he's quit taking Medicaid also. The phone call I got was he's stopping taking Medicaid patients.

And, then, when I got the notice about what I heard about UK, we went ahead and made the phone call to just try to verify that and we were told it's just adults only referral, on a referral basis.

So, I think we need to look into that a little deeper and just hope that's not the total case.

COMMISSIONER STECKEL: We'll look into it.

DR. BOBROWSKI: Okay. And, Ms. Steckel, do you have any other comments because I want to get into the section of individual Benefit Administrators. And we're so glad you were here today and offered some valuable information.

DR. McKEE: Don't be a stranger, right?

DR. BOBROWSKI: Don't be a stranger. Please come back.

COMMISSIONER STECKEL: Well, and that's what I'm trying to do is to make myself available if I can get everybody else to cooperate that I could be at all the TACs. It's important for us, for me to hear directly from providers. Yesterday I was out looking at a SUD provider and it just changes the way you think about things.

I always accuse CMS about sitting in their ivory towers and dictating to us when they don't have a clue how a state works. I don't ever want someone to accuse me of that here in the state. So, the more we can work together, the more we could come up with ideas.

What I find out is you guys will present an idea. We will take it in and work through it, and we can't do it this way but if we do it this way, it might work out and we've solved a problem and it can only be done by working together.

So, I thank you all, and bear with us as we work through the TAC and the MAC issues and the administration and all of that but your input is extremely valuable and this interaction is extremely valuable.

So, I know you take time away from your practices to help us and we are very, very grateful. And I'm sorry. We just don't want anything to go wrong with this bid, so, we're being hyper vigilant. So, thank you all very much.

(DMS staff leave the meeting room)

DR. BOBROWSKI: I wanted to go back to our Benefit Administrators' reports. I like to at least have it open on the floor so we can talk about issues or something. DentaQuest, were you all finished with yours?

MR. SMITH: We just wanted to inform you of some of our outreach efforts and stuff that we've been doing. Of course, missed and broken appointments is something that is still occurring.

So, we've always had a campaign around that where we do reimburse I believe it's $3 for missed and broken appointments using the proper Medicaid code on the fee schedule.

And what we do, using those claims, we're able to--so, we encourage you to send those because when we do those claims, we're able to actually do the outreach, send a brochure or make that phone call and say, hey, you missed your appointment, educate them to get back in there.

Then, we go a step further and looking at the claims research down the road saying, okay, how long has it been since that outreach was done, how many days did they go and do they finally complete that appointment that we wanted them to do. So, we're kind of doing some analysis around that, too. So, I wanted to share that because we're really paying attention to that because we know that does happen.

Also, I wanted to let Dr. Watson inform you guy about some of the summer outreach and things that we've been doing as well.

DR. WATSON: We've been really active in the community. We went down to Henderson and did a Career Fair there and was able to work on the under-insured and uninsured in that community, providing free care for them. We passed out about a thousand toothbrushes between about eight different health events within Louisville and in Western Kentucky area. So, we're trying to get into the grassroots and really be involved with the people and serve as many as we can.

MR. SMITH: That's about it other than that. Again, we're really spending this summer just really focusing on members, getting out

there in the community.

DR. BOBROWSKI: Thank you.

DR. SCHULER: I had a question. We got a letter about Dental Care Plus. Can you talk a little bit about the arrangement with Dental Care Plus?

MR. SMITH: Sure. I wish I had that letter right in front of me so I could go into detail.

DR. SCHULER: Me, too.

MR. SMITH: So, if I'm not mistaken, we're on the Exchange. So, we actually do have some dental plans that you can also get involved with. Again, I think someone actually brought that up where a member, again, if they're no longer Medicaid eligible, we do have some private insurances there that they can look into on the Exchange website there.

MS. HUSIC: Dental Care Plus is an Ohio-based group on the commercial side. We've acquired them, and starting January, 2020, we're actually going to be working under the same umbrella.

So, anyone who is already contracted with Dental Care Plus would keep the same rates that they have with Dental Care Plus and, then,

they would also be in network with DentaQuest.

And, then, aside from that, if they aren't already, they can enroll under their current DentaQuest rates.

In addition to that - and that would be on the commercial side, not the Medicaid side.

And, then, in addition to that, we also have two commercial plans that we've rolled out, the individual provider plan and also the marketplace which is geared towards the 100 to 300% of the poverty level. So, it's for individuals that may not qualify for Medicaid but it gives them access to the commercial plans at that level and, so, therefore, those rates are in accordance to the members that those services are being provided to.

DR. SCHULER: So, Dental Care Plus won't have any Medicaid component to it.

MS. HUSIC: That's separate. Dental Care Plus is strictly commercial. We have the two other DentaQuest plans that are also strictly commercial.

DR. SCHULER: So, if you're in network with DentaQuest, are you also in network with Dental Care Plus?

MS. HUSIC: On the commercial side, yes. You would be deemed in unless you choose to opt out.

DR. BOBROWSKI: Aetna.

MS. ALLEN: We'll do general updates for the MCOs. Just an FYI for the providers, we did do a restructuring of our Provider Relations' team. So, now we have more reps that are servicing all of our MCO partners where before we had Passport reps and, then, we had reps that serviced the other three. Now we have reps that are trained to represent all four of our MCO partners. That's one update.

DR. CAUDILL: As far as outreach ourselves, we were a major supporter of the recent RAM Clinic that took place down at Hazard where several hundreds of patients were treated free of charge, homeless, indigent people maybe just over the Medicaid line where they couldn't get Medicaid and it turned out to be a great success.

DR. SCHULER: Were those numbers back up to where they were three or four years ago? I know once they rolled out the Expansion, I was involved with a couple of them after that and the numbers were down dramatically because so many people

had picked up coverage.

DR. CAUDILL: And I've done MOM Clinics and RAM Clinics in my career, but I think the one in Hazard treated I think the numbers I saw were around 700 or 800 patients which is still a good number of patients. I did a MOM's Clinic where we did 1,400 patients.

So, we're doing our outreach there and we continue a major outreach and support of the Red Bird Mission Clinic in Eastern Kentucky and their outreach program as far as the rehab centers which is phenomenal what's going on there.

DR. GRAY: Did you all address the preauthorization of narcotics for children under eighteen?

MS. ALLEN: I thought you wanted to do that under New Business. If you'd like us to do that now, we can.

DR. BOBROWSKI: Let me bring that up in a minute. Humana.

MS. ALLEN: What we stated represented the four that we represent.

DR. BOBROWSKI: I didn't know if you had anything different to add. So, Passport and WellCare is all the same.

MS. ALLEN: Same family.

DR. BOBROWSKI: Okay. Dr. McKee, do you want to say anything?

DR. McKEE: Yes. I'll say what I was going to say. On the public health hygiene program side, we had ten programs out in the state. One of them has decided not to do a public hygiene program and it's a big loss. It's Lincoln Trail which is a multi-county thing.

They have been convinced - Julie is not convinced - that a mobile unit is serving all the schools in that area dentally. So, we'll see about that.

We don't expect any expansion in this program in the health departments because the start-up funding is gone, but the biggest one is that health departments are undergoing transformation right now and they are really, really buckling down.

This is not official but this is Julie's take. What do I do as a Health Department that keeps me out of jail and that my community said that they want and that's about it. You're going to see Health Departments look different.

Now, the other nine Health Departments are continuing this program but they're

kind of waiting to see how that goes. And with reimbursement issues that are more on our clearinghouse side than it is on the MCO side, that's a big issue because it's a cash flow problem. So, I wanted to let you know about that.

Two things about telehealth and teledentistry. One thing is there are four Health Departments that are ready for teledentistry. They work with partners. They've got the dentists signed up. They've got the equipment, the software, whatever.

They've got it and they're ready to go and really excited about that but that brings me to my second point about that is they are only allowed to do that in a live situation because the telehealth regulations came out and we were all excited them and it limited the store-and-forward standard to radiology only.

I thought that when we had our last meeting, I thought that dentistry would be the only ones raising Cain about this but we had good input from dermatology, from ophthalmology, from behavioral health, things like that, that they were also upset.

And we were told by a Medicaid

official that basically it was a budgetary thing. They just did not want to have that huge expense that they were anticipating, and I don't know if they got the message that this is a return on investment to get those people into care quicker to do that.

Now, going forward with our programs, our public hygiene programs with teledentistry, we're going to try to do it live. That really limits our encounters with our local partners because store and forward is the dentistry standard for teledentistry and we're not allowed to do that.

And I just wanted to put a question to the Commissioner. I believe they got a lot of feedback on that regulation. I know there were some official ones. I don't know if they had any hearings or not but I wanted to know when it was going to be responded to and/or finalized. That was my question.

DR. CAUDILL: Avesis did submit our comments through our MCO partners and, then, one directed us to submit directly to the State.

DR. McKEE: I believe the Kentucky Dental Association also did.

DR. CAUDILL: And I think KDA

did. I know the KMA did.

DR. McKEE: Hygiene did.

DR. CAUDILL: Again, that's the model in dentistry where it works, where you can send out a team and not necessarily be a doctor on that team but a hygienist working under general supervision could gather the data and send it to a doctor at the hub and then triage, get a treatment plan and then send the team back out to do everything they can do under general supervision such as prophy fluoride, sealants and so forth.

So, yeah, we had it all set and ready to go, as you know, and then we were all shut down. So, according to the official--I mean, this is the emergency reg we're working under right now and then working towards the permanent reg, and that emergency reg can last, what was it----

MR. OWEN: Seven months. They have to file their response by September 15th.

DR. CAUDILL: That helps. Thank you very much.

MR. OWEN: Then, there's a legislative committee that will review it in October. So, there's also an option to lobby the committee.

DR. McKEE: Which I can't do

obviously.

DR. HOAGLAND: I think some of the problem is everything encompassed within that, the scope is very different and the potential implications were all very different in that. So, I wonder if that is where some of the complications were.

As one person who is looking at it both from a consumer standpoint, a payor standpoint but, then, also a deliverer-of-care standpoint, the blanket caused me a little bit of concern across all provider types because it wasn't necessarily standard practice for all provider types but it could be open to that.

Without counter kind of quality control in place, I think it was a bit of a concern and that application in particular for open access type of services, if the definitive treatment or more definitive treatment plan isn't offered to the member at the time that they're receiving the care for some services, then what happens because you may lose them at that point.

I think for more for a consultative model, it makes a lot of sense, but if it's more of a primary care delivery or direct access

delivery, then, it seems like there's a difference in scope that wasn't really ever captured in the language that I saw in the proposed regulation.

DR. CAUDILL: The pilot we were looking for was delivery of preventive care. Obviously you're going to have to have a doctor onsite if you're going to do anything other than that if it's outside their scope.

DR. HOAGLAND: Again, unfortunately, I think the dentistry piece may have gotten wrapped up into a broader question that was out there.

Again, for a lot of the fields of health care beyond dentistry, that application of technology is still being kind of scoped out and developed, but could there be an opportunity to put those into different categories? Everybody wants things to be simple but sometimes it has to be a little bit more defined to make all the different stakeholders comfortable just as a thought.

Dr. McKee, Lincoln Trail, is that mobile provider in combination with the FQHC they are working with for school health?

DR. McKEE: No, I don't believe so.

DR. WISE: What county is this?

DR. McKEE: It's like Hardin, LaRue, Marion, Washington and Nelson.

DR. HOAGLAND: I thought that they were working with - I can't remember which FQHC it is. I thought they had dental services available at some of their locations but it's interesting that they would go outside of that for their school-based services.

DR. McKEE: I'm just telling you what I----

DR. HOAGLAND: No. I understand. I understand.

DR. CAUDILL: And we have some large, mobile, commercial organizations in the state which was part of our reining-in process.

DR. McKEE: Thank you for listening. I'm done. I have an eleven o'clock meeting.

DR. BOBROWSKI: Thank you. Some of the other things on the agenda we've kind of hinted at and talked a little bit about.

The Passport/Evolent Health status, I know it's been worked on and we talked about some of the other things I had on the agenda

already. So, unless you've got something else to bring up, we can keep moving.

DR. HOAGLAND: Well, there are some specifics that I think there will be more conversations about. Just in general related to our health program and how all the different pieces of health benefit come together to help meet the needs of a member, our intention is to not be outliers. We understand that that may not have occurred.

Working closely with our business partner, Avesis here, we're open to ongoing conversations about how we assure as best we can that there's not just adequacy. We've heard a lot about adequacy and the reality is that we want access and one is a desktop exercise in my mind.

You can plug a computer-generated model in and figure out do you have enough bricks and mortar and enough bellybuttons in a particular location to theoretically meet the needs but how do you really measure access?

Are you actually getting your members in to be seen and not just a person but is it good quality care and it's leading to the result that you want and I think that's the additional conversation we need to have. You have to have a

base reimbursement model to help support that.

We understand that and I think we're committed to having that conversation with individual groups.

DR. BOBROWSKI: I put that on there and I brought photos. The day-to-day folks that we see, okay, and I'm surprised they're not hurting pain-wise more than they are. We feel for those folks. I know you all do, too.

And it's like the big conversation today has been cost effectiveness. And when each of the MCOs or Benefit Administrators keep reducing their reimbursements, you all know that a lot of times you don't do this to make money.

You do it because you care about people in your communities. You hope you make some to keep the lights on, maybe put back a few dollars so that when the roof leaks, we have to bear that burden ourselves. It's not like this roof where they call somebody else and fix it. It's out of my pocket to fix that roof.

DR. HOAGLAND: I can appreciate that and I think everybody is aware that there's competing pressures that exist and trying to figure out how to do it. At the end of the day, my

responsibility is to try to help make the total picture work for health care benefits for our membership.

And, so, does that mean that there's an opportunity to invest in one place more than another? Yes. I think we have to understand how to do that and that's working together to make that happen.

It's not just--in my perspective, and I don't mean to to be pejorative, it's not only a conversation with our partner, Avesis, as far as dental benefits management. It needs to roll back to a much larger conversation about how do we reconcile the total health of our membership - at the micro level, one person at a time, but, then, also at the 300,000 membership level as well.

So, how can we make that sustainable and getting to where we want it all to be and there's lots of puts and takes in that; but in order to do it, you have to bring all perspectives, all stakeholders together to do it.

So, we're committed to working with you in doing that for that very important piece of our benefit.

DR. BOBROWSKI: Sometimes I use myself as examples but I get phone calls and texts. I'm not the only one in this boat. But, for instance, I got a letter about six weeks ago from my IT folks that help us with servicing our computers.

Well, they don't know until they get into it of the exact cost, but they've kind of given me a top number and this has got to be done by I think it's January 12th. And that sounds like a long way away but it's not, and I'm looking as an individual Medicaid provider of $34,000 to upgrade from Windows 7 which won't be compatible in January for HIPAA. It won't be supported anymore.

Now, how many extractions at $34.20 do I do to make up $34,000 which doesn't make me a penny? You're down at that real micro level of treating patients and your providers of being able to continue to provide those services. And I'm so glad to hear that they're finally looking at some of these issues.

And the other phone call I got was an Eastern Kentucky dentist who has just closed their doors because they can't pay the bills. It's a high Medicaid office. I got a phone call, a very reputable person that I got the phone call from but

sometimes there are other factors to cause somebody to go out, but the word was that with the rates they are getting, they can't pay their bills.

So, it was a very high Medicaid office. And, like I said, you have to take a little bit of this anecdotally but it does affect it.

The letter we got from Humana and CareSource, the partnership termination says that it's still going to be business as usual. So, we're good there.

Dr. Gray left. I did want to talk a little bit about the prior authorization requirements for narcotics of eighteen-and-under patients. Before you all got here, I talked with Dr. Caudill a few minutes about that.

We always get the negative side of the phone calls first, and Dr. Caudill knows that we have been working very hard on the narcotic use in this state. So, I can see where this has got pluses, some negatives but let's talk about it.

DR. CAUDILL: So, let's talk about it. And I want to clarify. This is only for Aetna right now.

Aetna corporate at a national level has made the determination in their fight

against the opioid epidemic across our nation but also Kentucky is one of the Ground Zeros of the epidemic - Kentucky, West Virginia and so forth - so at a national level, they've looked at the research.

And I brought three articles here for you all to share with each other, one in 2018 from JAMA where the study showed that a cohort of teenagers who received opioids primarily after third molar extraction - and we all know that magic window is somewhere between sixteen and maybe eighteen, twenty is when they get them out before the root formation fully forms on those third molars, they're easier to get out at that point.

Because that was their first exposure to opioids at that point, they had a 6.8 increase risk of persistent opioid use and a 5.4 increase two years later of being addicts, of becoming dependent.

So, that's pretty startling information, just saying, okay, their first exposure is their wisdom teeth. You give them a narcotic and a substantial number go on to become addicts based on that first exposure at that age. Okay. So, that's the first one.

We go on over. The FDA has

released guidelines and this drug safety communication on the restriction on codeine and cough medicine and Tramadol; but inside here, if you go on to the second page, it says health care professionals should be aware of Tramadol and codeine should be used only in adults, consider recommending OTC such as Ibuprofen and Tylenol. That's becoming the standard for children younger than twelve and adolescents younger than eighteen. We should not be giving narcotics to teenagers.

And another study also shows that when adults get these narcotics, they only use about 38% of the prescription and the rest is sitting in their medicine cabinet and, then, teenagers get access that way and get their first exposure to opioids. So, that's that one.

Then we go on to the American Association of Oral and Maxillofacial Surgeons' White Paper on pain management and I think this preface is pretty telling. Because prescribing protocols evolve over time, practitioners also should stay informed of the latest public health trends, including possible alternatives to opioid pain treatment.

I sit on Guardian's National Panel for Opioids and I teach courses on this and do

webinars on this subject nationwide, and AAOMS' own guidelines say providers should prescribe non-steroidal anti-inflammatories, NSAIDs, as the first line of analgesic therapy. And if NSAIDs are contraindicated, then, you should start with Acetaminophen.

It should not be every time you get your mouth worked on, you get a narcotic. That's not the standard of care anymore, folks. We've got all the national organizations coming out against doing that.

So, AAOMS is taking the stand that we're not going to just automatically approve prescriptions for eighteen and under because the research is saying and even the FDA is saying we should not be doing that. So, we're taking a pretty strong stand at this point on that subject.

Now, they're not saying you can't but they're saying we're not going to pay for it unless you do a prior authorization.

And I wish John was in here but we did meet with them on this subject yesterday and went to it in depth and I just wanted to share. I mean, I can give you lists of articles on this subject but these are just three representative of

the path our nation is going away from opioids on teenagers.

So, the position is, yes, we can approve it but it's going to take a prior auth. Now, initially, I think the notice is going out they were talking like it was going to take twenty-four hours.

Aetna is certainly willing and they expressed this yesterday to sit down with us and come up with a streamline method that if a surgeon feels this is going to be a special case with substantial pain, of break-through pain and they can make their case, that they will try to come up with a streamline method for an ASAP and get it approved, but as far as just as a general rule everybody gets an opioid, they're not going to go there anymore. At least they're not going to pay for it.

DR. BOBROWSKI: I wanted to compliment you all. I got phone calls on the negative side of it just for the administrative cost of getting those prior authorizations. It becomes a - you've been there. I mean, a lot of you all have been in the offices. It just becomes a daily struggle with the administrative burden on getting things done, and I think that was the thing.

And if there's a way to get that streamlined. I mean, you've got a kid that wrecks on a bicycle and half their teeth are busted out.

And I want to brag on the KDA just for a minute. Last year - you were talking about a list this long of references - that's what we have done at the KDA on our opioid document and we got that done last year. As a matter of fact, we used that same--the oral surgeons' paper and referenced it. We've referenced other states of what they're doing.

But in some of the research that I did on that was sometimes - and this is what's amazing - sometimes a young person could take five opioid pills and be addicted. I mean, it can be two days of treatment of those pills and they're hooked. It's brain receptors and all this chemistry and neurology that goes with it and behavioral stance.

The whole thing we've got on there on the KDA site, we've worked with the folks here in Frankfort, too, that some things need to be updated. This thing is a moving target keeping up with it.

I personally haven't had time

to work on the KDA's website document. It's on my to-do list. My kitchen table has turned into another desk.

DR. CAUDILL: I can add some more color to this on the Aetna thing also. I don't think I've shared with this group yet that we did an opioid project last year and sent letters out because we did a data run. Normally I can't see the data on your prescribing habits.

So, we partnered with Aetna and looked at the pharmacy side on all the dentists in the network who were providing narcotics for more than three days which three days is now our guideline in Kentucky. We found 241 unique providers doing that.

DR. SCHULER: Doing what, the three days?

DR. CAUDILL: More than three days, some up to thirty days.

MS. ALLEN: On 780 unique patients.

DR. CAUDILL: So, we sent out a co-branded letter, Aetna and Avesis, in December not threatening anybody but just saying, hey, guys, we've looked at the data. You're showing as an outlier,

and we told them exactly how many prescriptions they had written for more than three days on the number of patients.

So, they knew exactly what we were saying and we were just saying based on AMOS guidelines and FDA guidelines and ADA guidelines, you probably need to reevaluate your prescribing habits. So, we did that, non-threatening, just please take a look.

We then re-ran that data in May, five months later. That number had gone down over 90%, over 90%. That's huge. That blew the doors off, and I'm calling these doctors personally and doing follow-ups myself, especially the ones that were writing thirty days, twenty-five days, twenty days.

Doc, what's going on? And they're saying, Jerry, I'm sorry, you know, I've been in practice a long time and I was just on auto pilot from all the years ago and really not paying attention to what I was doing. They didn't really take it as an insult or an attack. It was just like, you know, I really didn't realize.

So, a huge change, a huge change. And, then, we ran the report again and we

only came up with twelve more docs, twelve new docs. So, we've talked to them now.

So, sometimes it's just information and bringing it to someone's attention to get that kind of a swing, over a 90% change. So, we've already cut back the opioid prescribing by dentists in this state now substantially.

DR. BOBROWSKI: That's great news. In my mind, to me, the Benefit Administrators, it should be their job to first look at the outliers and see what the situation is. When something happens, don't automatically have a knee-jerk reaction and come up with a policy that affects all of dentistry for a handful.

Just like you said, I think the way that was handled is the way it ought to be handled personally. Well, if there's outliers, call them first. They're the ones that's out there. So, I think that was well-handled and just something for us to look at on all of our daily activities treating patients.

DR. CAUDILL: So, I hope the TAC will agree that we're taking a prudent step here to protect our children in Kentucky and we're trying to do it in a logical manner and I've got the

commitment from Aetna that they will try to work with us to streamline the process a little more for you for those urgent ASAP, I've had to do major, major surgery here and I may need some pain medication for this kid; but as a standard, everybody gets the standard script, that's not going to fly.

DR. SCHULER: Garth, do you have much more? The only reason I ask is I'm going to have to leave and you're going to lose your quorum.

DR. BOBROWSKI: Do you all feel like there's anything here today that we need to bring up as a vote so that we can get it to the MAC?

DR. WISE: I think we need to make the modifications on the ortho thing.

DR. SCHULER: Why don't you make that and then I will present it to the MAC.

DR. BOBROWSKI: Okay. I'll make a motion that we have the KDA workgroup who has presented their report today be presented to the MAC. I'm kind of leaving that open a little bit there because I think there's a couple of things that needed a little tweaking.

DR. SCHULER: After you get that all buttoned up, do you want to send that to me

and I'll be more than happy to present it to the MAC?

DR. WISE: Yes, sir.

DR. BOBROWSKI: All in favor, say aye. Okay. We've got that moving then. Again, thank you all who were participants in that workgroup.

Are there any other comments from any other dentists, hygiene or te public?

We got the motions done. The next meeting is November 13th on a Wednesday.

If there's no other business to come before this meeting, the meeting is adjourned.

MEETING ADJOURNED